SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: ELIGIBILTY FOR SERVICES
	Subject: New Admissions

Reference: ARM 37.40.1005 and ARM 37.40.1114

DEFINITION

This policy outlines the referral process and initial admission for individuals who are new to the Self-Directed (SD) Community First Choice/Personal Assistance Services (CFC/PAS) program. For high risk intakes refer to SD-CFC/PAS 414.

REFERRAL SOURCE PROCEDURE

1. Referral source collects as much of the following data as possible from individual/ family member:

    a. Name, date of birth, address, phone number, Medicaid identification number (when known), responsible party/Personal Representative (PR), health care professional, diagnosis, synopsis of need, involvement with other services, and other relevant information.

    b. If the referral source is a CFC/PAS provider agency the following applies:

        i. Provider agency determines whether the individual meets the policy/criteria for CFC/PAS:

            1. If the individual does not meet criteria (does not require help with any activities of daily living, is not Medicaid eligible, etc.):

                a. If the individual agrees that they do not meet policy/criteria for CFC/PAS, the referral process ends.

                b. If the individual disagrees with the provider agency determination and the individual is Medicaid eligible, the provider agency transmits the Referral form (SLTC-154), to

Mountain Pacific Quality Health (MPQH) with the reason for ineligibility. MPQH verifies the reason for ineligibility and notifies individual of ineligibility, provides fair hearing rights, and enters reason for denial in database.

2. If the individual meets the criteria for CFC/PAS:

   a. Provider agency transmits Referral (SLTC-154) to MPQH via fax within one working day. If the provider agency is uncertain whether a member will qualify for CFC/PAS the agency should submit the request and let MPQH complete the referral.

      NOTE: The provider agency cannot determine whether a member is eligible for the CFC service option. That determination is made by MPQH upon completion of the referral paperwork.

MPQH REFERRAL PROCEDURE

1. MPQH inputs information from referral into their database, checks Medicaid financial eligibility, and provides basic information on the CFC/PAS program to the member when requested. If the member is not currently Medicaid eligible, but has applied for Medicaid, MPQH will not process the referral until Medicaid eligibility is determined.

2. Once Medicaid eligibility is determined, MPQH assigns referral information to the MPQH nurse coordinator.

3. MPQH nurse coordinator completes an onsite review within 10 working days of MPQH receiving the referral.

   NOTE: If the onsite review cannot be completed within 10

working days, a pre-screen will be conducted (refer to pre-screen section below).

4. MPQH completes level of care assessment within 10 working days of receiving the referral. If the member has an intellectual disability and MPQH is unable to determine level of care, MPQH will make a referral to the Developmental Disability Regional Office.

5. Once the onsite visit is completed, the MPQH nurse coordinator sends the Member Overview (SLTC-154) with the choice of provider agency identified to MPQH Central Office for processing.

6. MPQH inputs information into database and faxes Member Overview, Service Profile, and Capacity Assessment (SLTC-154/155) to the member's provider agency of choice and the Plan Facilitator.

    a. The Service Profile will include the program type the member has selected. There are four program types:

        i. Agency-based Community First Choice;

        ii. Agency-based Personal Assistance Services,

        iii. Self-directed Community First Choice; and

        iv. Self-directed Personal Assistance Services.

    The Service Profile will also include the provider agency selected and the Plan Facilitator.

7. MPQH sends notice to member (SLTC-151 Personal Assistance Services Authorization).

PROVIDER AGENCY REFERRAL INTAKE PROCEDURE

1. Provider agency determines that they are able to accept the referral.

    a. Member/PR is educated regarding program parameters and expectations.

i. The Health Care Professional (HCP) Authorization is provided to the member/PR that is responsible for obtaining HCP approval on the HCP form (SLTC-160) once the Service Plan is completed. (Refer to SD-CFC/PAS 418).

ii. Completed HCP form is returned to the provider agency prior to the implementation of services.

b. ➢Provider agency Program Oversight staff and the member meet in- person in the member's home to complete the intake process. Refer to CFC/PAS 702. If the member has a PR both the member and the PR must be present in the member's home during the intake visit.

i. If the provider agency is the Plan Facilitator, the Plan Facilitator must participate at the intake meeting and complete the Person Centered Planning (PCP) form (SLTC-200). The provider agency Program Oversight staff must complete the Service Plan (SLTC-175) and ensure the Member/PR Agreement (SLTC-159/166) is reviewed and signed.

ii. If the case manager is the Plan Facilitator the provider agency must coordinate with the case manager to ensure that the Plan Facilitator completes the PCP form. The provider agency oversight coordinator must use the PCP form to guide the development of the Service Plan. If the provider agency does not have a PCP form when they meet with the member/PR., (i.e. a coordinated visit does not occur) the provider agency must develop the Service Plan according to member preferences and ensure a PCP form is completed.

1. Provider agency must contact the Case Manager Plan Facilitator and inform them that the member is enrolling to CFC/PAS.

a. The provider agency must determine the month of the annual case management visit.

2. Case Manager Plan Facilitator is

responsible for completing the CFC/PAS PCP form. The Case Manager Plan Facilitator may complete an in-person on-site coordinated visit with the provider agency or complete the planning requirements over the phone. (Refer to CSB 1104 and 1107 for Plan Facilitator options for completing the form).

3. Provider agency oversight staff must complete the Service Plan and ensure the Member/PR agreement is reviewed and signed.

   a. If the Case Manager Plan Facilitator is not present at the agency's intake visit, the agency must obtain the Plan Facilitator's signature on the Service Plan within 10 working days of completing the intake and distribute to the member and Plan Facilitator within 30 days.

   b. If the Case Manager Plan Facilitator is not present at the provider agency's intake visit, the Case Manager Plan Facilitator must complete the PCP form within 10 working days of the member's intake. The Case Manager Plan Facilitator is responsible for obtaining the provider agency oversight staff signature on the PCP form within 10 working days of completing the PCP form and distributing copies of the form within 30 days.

   c. If the PCP form indicates a preference that is not captured on the CFC/PAS Service Plan, the provider agency must complete an amended Service Plan to reflect the preferences indicated on the PCP form within 10 working days of receiving the form.

c. ➢Provider agency has ten days to submit the Agency Admit form (SLTC-163) to MPQH after the in-person intake visit is completed.

d. ➢Provider agency provides the member and the member's Plan Facilitator with a copy of the Admit form.

e. ➢Provider agency begins attendant services as soon as possible after insuring all necessary documents are completed.

i. ➢If the provider agency cannot begin services within a reasonable amount of time after the intake visit, the agency should follow-up with the member and document the reason for the delay in delivering services. The member has the option of switching agencies, discharging from services, or staying with the current agency.

1. ➢If the member elects to switch agencies, the member must contact other agencies to determine whether another agency can serve them. The provider agency should follow the Request to Change Agency policy (Refer to CFC/PAS 412).

2. ➢If the member elects to discharge from services, the provider agency must discharge the member.

3. ➢If the member elects to stay with the current agency, the agency has up to 45 days from the date of the intake visit to serve the member. If the agency cannot serve the member within 45 days the agency must discharge the member.

4. ➢When the provider agency discharges the member (scenario 2 and 3 above), the provider agency must submit the Unable to Admit/ Discharge form to MPQH within ten days and follow the discharge policy (Refer to CFC/PAS 705).

PRE-SCREEN:

1. If a MPQH nurse coordinator's travel schedule does not allow for an onsite review within 10 working days of receiving the referral, MPQH may pre-screen the member over the phone. A phone pre-screen review must be completed within 10 working days.

2. Pre-screen review collects the following: demographic information, review of member's service needs, preliminary authorization of hours, authorization of days per week by task, screen for capacity, document choice of agency, and schedule the on-site visit date. The onsite visit must be made within 30 working days of MPQH receiving the referral.

3. Pre-screen review includes the initial determination of level of care.

    a. If level of care cannot be determined, a referral will be made, as appropriate. If level of care cannot be determined in 10 working days, MPQH will default the member to the personal assistance program until level of care is determined.

    b. If level of care can be determined within 10 working days, MPQH will include the determination of level of care and program option type (i.e. CFC or PAS) on the Service Profile.

4. MPQH provides Page 1 of the Referral/Overview and a Service Profile to the provider agency the member selects and the Plan Facilitator. MPQH will notify the referral agency when the member selects a change in provider agency if a high risk intake has occurred. (Refer to SD-CFC/PAS 414).

5. MPQH provides a complete Overview and a Service Profile after completion of the on-site home visit. If the Service Profile authorization is different than the prescreen authorization, the agency has 10 working days to institute the new authorization and complete an Amendment to the Service Plan.